HCPS
Henrico County Public Schools

HENRICO COUNTY PUBLIC SCHOOLS MIDDLE SCHOOL STUDENT PARTICIPATION, PARENTAL APPROVAL AND PHYSICAL EXAMINATION FORM

(TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN, STUDENT AND PHYSICIAN)

VALID MAY 1 - JUNE 30 (14 MONTHS)

Student's Name _____ Birth date _____ Age _____
Grade _____ Sex M [ ] F [ ] Home Phone _____ Cell Phone _____
Parent/Legal Custodian's Name _____ Work Phone _____
Home Address of Student _____ School _____
Emergency Contact Person (other than parent/custodian) _____ Phone No. _____
Family Physician _____ Phone No. _____
Hospital preferred _____ ALLERGIES _____
MEDICATIONS (current) _____ Last Tetanus Booster Date _____

History of:

	(Circle)			(Circle)	
1. Any injuries requiring medical attention	Yes	No	5. Hospitalized (except for Tonsillectomy)	Yes	No
2. Under a physician's care at this time	Yes	No	6. Any chronic disease	Yes	No
3. Wears glasses or contact lenses	Yes	No	7. Any reason why this individual should not participate in competitive sports?	Yes	No
4. Surgery or operations					

If "Yes" to any of the above, list appropriate number explain _____

_____

In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ Middle School to hospitalize and/or secure proper treatment for the student named above.
I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions.

My child is covered by an insurance that meets my approval.
Company name _____ Policy Number _____
_____ My child is covered by 24 hour school insurance _____ My child is covered by School Day insurance.

PARENT/LEGAL GUARDIAN'S SIGNATURE _____ Date _____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Board of Control for Middle School Athletics.

STUDENT SIGNATURE _____ Date _____

The proponent for this form is: DIVISION OF INSTRUCTION, Tel. 652-3761 Stock No. 1301-150 DISCARD ALL OTHER FORMS. REV. 8/27/01

Physical Examination
(To be completed and signed by examining physician)

Name of Student _____ School _____
Age _____ Height _____ Weight _____ B/P _____ P _____ R._____
Eyes _____ R20/ _____ L20/ _____ Ears _____ Hearing R _____ L _____
Cardiovascular _____
Respiratory _____
Liver _____ Spleen _____ Hernia _____
Musculoskeletal _____ Skin _____
Neurological _____ Genitalia _____

I certify that on this date I examined this student and on the basis of this examination, along with the medical history furnished to me, I found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

COMMENTS: _____

_____

_____

Physician's/Nurse Practitioner's Signature _____ Phone No. _____

Address _____

Date of Examination: _____

NOTE: THIS FORM MUST BE COMPLETELY FILLED OUT AND MUST BE FILED IN THE SCHOOL HEALTH OFFICE PRIOR TO THE STUDENT'S PARTICIPATION.

Student-Athlete Concussion Policy

The General Assembly amended the *Code of Virginia* requiring each school division to develop policies and procedures regarding identification and handling of suspected concussions in student-athletes in the Commonwealth of Virginia. One part of this requirement is annual review by student-athletes and parents, information on concussions provided by the school division. This information can be provided by handouts, parent meetings, workshops and other methods individual schools deem appropriate. Included below is basic information on concussions and a Statement of Acknowledgement. This form must be signed and returned to the student-athlete's school in order to participate in any extracurricular athletic activity.

What is a concussion? A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious.

SIGNS AND SYMPTOMS OF A CONCUSSION

SIGNS OBSERVED BY PARENTS OR GUARDIANS

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events prior to the hit, bump, or fall
- Can't recall events after the hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Forgets class schedule or assignments

SYMPTOMS REPORTED BY YOUR CHILD

Thinking/Remembering
- Difficulty thinking clearly
- Difficulty concentrating or remembering
- Feeling more slowed down
- Feeling sluggish, hazy, foggy, or groggy

Physical
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Fatigue or feeling tired
- Blurry or double vision
- Sensitivity to light or noise
- Numbness or tingling
- Does not "feel right"

Emotional
- Irritable
- Sad
- More emotional than usual
- Nervous

Sleep*
- Drowsy
- Sleeps less than usual
- Sleeps more than usual
- Has trouble falling asleep

* Only ask about sleep symptoms if the injury occurred on a prior day

Information provided by U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC)

We acknowledge we have received and reviewed information provided by our school on the risk and recognition of concussions in student-athletes. We also understand review of current information on concussions shall take place annually in order to participate in Henrico County Public Schools athletic activities.

Printed Student's Name/Grade _____ **Student's Signature/Date** _____

School _____ **Parent's/Guardian's Signature/Date** _____

COVID-19 Health Screening Acknowledgement Form for Students

Screening, monitoring and testing are essential components of limiting the spread of COVID-19. To help safeguard students, employees and visitors in Henrico County Public Schools against the spread of the COVID-19 virus, HCPS has established a home-health screening practice for its students during the COVID-19 pandemic. Each student must have a screening of his or her health status performed at home, which consists of reviewing the Virginia Department of Health (VDH) Survey for Student Self-Administration, and having their temperature taken at home before reporting to any school or school-sponsored activity.

As a condition of participation all, the student and his or her guardian must agree to perform this screening (see page 2) each day they are on school property and not come to school or a school-sponsored activity if they are sick or answer yes to any of the questions. The parent or guardian should seek guidance from his or her child's health provider should they answer 'YES' to any of the questions below or have a fever of 100.4 degrees F or higher. Please notify the school or sponsor of the student's absence. By coming to school or participating in a school-related activity, the student and his or her guardian is attesting the answers to all of the screening questions were 'NO.'

Falsifying answers or failing to perform this health screening may result in a loss of privileges.

I acknowledge that I have reviewed and understand this document. I understand these protocols, and I know the screening questions may be updated as necessary to adhere to changing guidance from the VDH. I agree to fully comply with the COVID-19 Health Screening Protocol for Students and to follow the protocols outlined in this document.

_____	_____
Printed Name of Student	Printed Name of Parent/Guardian
_____	_____
Signature of Student	Signature of Parent/Guardian
_____	_____
School/Activity	Date

COVID-19 Health Screening for Students

VDH Survey for Students:

Answer 'YES' or 'NO' since your last day at school or school-sponsored activity, has your student had any of the following 10 symptoms or experienced either of the two situations listed below?	**Yes**	**No**
Chills, fever (100.4°F or higher) or a sense of having a fever		
A cough		
Shortness of breath or difficulty breathing that cannot be attributed to another health condition		
A runny nose, congestion and/or sore throat		
A headache		
Chest pain or pressure		
Muscle aches (myalgia)		
General malaise or fatigue (extreme tiredness)		
Loss of taste or smell		
Gastrointestinal symptoms to include nausea, vomiting and/or diarrhea		
Has your child had a positive test for the virus that caused COVID-19 disease within the past 10 days or is going to get tested for COVID-19?		
In the past 14 days, has your child had close contact (within about 6 feet for 15 minutes or more) with someone with suspected or confirmed COVID-19?		

If the answer to all items was NO, your student can proceed to school/activity. Don't forget a face covering!
If the answer to any item was YES, <u>do not</u> report to school/activity and contact the school or sponsor of activity to notify them of the student's absence.